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TENTATIVE DRAFT

I. INTRODUCTION

The Department of Institutions is the designated mental health authority for the State of Montana. Unless otherwise indicated, the Department of Institutions will be referred to in this Plan as the "Department." Legal mandate for the development and implementation of this Plan is provided in Title 53, Chapter 21, Part 2, Montana Code Annotated (MCA). Part B, Title XIX of the Public Health Services Act authorizes federal funding through the Alcohol, Drug and Mental Health Administration Block Grant and PL 99-660 establishes requirements for state comprehensive mental health plans.

I.1 Purpose of Plan

The Montana Mental Health Plan will guide and coordinate the development and implementation of mental health services in Montana consistent with state statute and the requirements of PL 99-660. The Plan provides a basis for the effective and efficient allocation and utilization of current federal and state funds available for mental health services. It is responsive to changing needs, services, and resources. Its development was based on input from Montanans representing diverse interests and points of view. The focus of the Plan is on priority populations consistent with state and federal priorities.

I.2 Mission Statement

The Department's mission for mental health services is to develop a comprehensive public mental health system which: 1) provides treatment, rehabilitation, and support services for psychiatrically disabled adults; 2) provides treatment and support services for emotionally disturbed children/adolescents and their families; and 3) assures the availability of basic mental health services, including emergency services and short term outpatient therapy in areas of the state where mental health services are otherwise not available.

I.3 Statement of Principles

The Department adheres to the following set of principles as guidelines for making decisions regarding priorities, goals, objectives and the future direction of the mental health system:

1. Services should be based on the needs of clients rather than the needs of the system, the Department or mental health providers. No system can provide the optimal set of services for every client; however, a client's needs must be the predominant factor in planning services. Services should also incorporate consumer self-help approaches and be provided in a manner that promotes clients' retaining the fullest possible control over their own lives.

2. Services should be flexible and allow for the special needs of both individuals and subgroups of clients. Programs should be developed or adjusted to meet the special needs of such subgroups as Native Americans and other ethnic minorities, the elderly, and mentally ill people who are also mentally retarded, chemically dependent or homeless.

3. Services should be offered in the least restrictive, most natural and least disruptive setting possible. Clients should be encouraged to use the natural supports in their community and should be integrated to the greatest extent possible into the normal living, working, learning and leisure time activities of the community.

4. Services should be built on the assets and strengths of clients to help them maintain a sense of identity, dignity, self esteem and independence.

5. Services should seek to prevent clients from harming themselves or others and from being harmed by members of the community.

6. Service systems funded by the Department should be accountable to the users of the services. The needs, preferences and rights of consumers

should be of major importance in planning and operating the mental health system. Consumers should be involved in the decision making process as individuals at the treatment level and collectively at the systems level.

7. Effective service systems are dependent on sufficient numbers of competent, motivated, sensitive and caring staff. Therefore, issues involving the availability, distribution, competence, and appropriate utilization of staff must not be overlooked.

II. POPULATION ANALYSIS

This section of the Plan includes a discussion of six populations of consumers:

1. Adults with severe and disabling mental illness.
2. Children and Adolescents.
3. Elderly people with mental health problems.
4. Minorities with mental health problems.
5. Homeless mentally ill.
6. Adults, ages 18-64, with mental health problems. (This group consists primarily of non-elderly adults who do not have disabling mental disorders)

Because these six groups are defined according to several different variables (e.g. level of disability, age, ethnic status, etc.) they overlap each other, allowing one individual to have membership in two or more categories. These groups were selected for discussion in this Plan based upon priorities set by state and federal governments and the interest expressed by Montanans who provided input to the planning process.

A description of how the Department defines priority populations for mental health planning and fund allocation is contained in **Appendix A.**

II.1 Adults with Severe and Disabling Mental Illness

A major responsibility of the state and federally funded mental health system is the provision of treatment, support and advocacy for individuals with severe, disabling mental illnesses. Historically, this responsibility has been met by large state institutions where many mentally ill patients spent much or all of their lives. In recent years, society has become more sensitive to the civil liberties of people with mental illnesses. At the same time, advances in treatment techniques and approaches to community support have occurred. As a result, the great majority of individuals with severe, disabling mental illnesses can and should be served within Montana communities.

The Department has defined an adult with a severe disabling mental illness as a person who is 18 years old or older and who meets criterion 1 and criterion 2.

Criterion 1 The person has a severe mental illness as indicated by one of the following:

a. the person has been hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital (Warm Springs campus) or Rivendell of Billings (former Montana Youth Treatment Center) at least once, or

b. the person has a DSM-III-R diagnosis of schizophrenic disorder (295), major mood disorder (296.2, 296.3, 296.4, 296.5, 296.6, 296.7, 301.13); paranoid disorder (297.10); organic disorder (290, 293.81, 293.82, 293.83, 294.00, 294.10, 294.80, 310.10); or other psychotic disorder (298.80, 295.40, 295.70, 297.30, 298.90); or

c. the person has a personality disorder (DSM-III-R code 301) which causes the person to be unable to work competitively on a full-time basis or unable to maintain a residence without assistance and support by family or a public agency.

Criterion 2 The person has ongoing functioning difficulties because of the mental illness, as indicated by one of the following:

a. the person takes prescribed medication to control the symptoms of mental illness, or

b. the person is unemployed or does not work in a full-time competitive situation because of mental illness, or

c. the person receives SSI or SSDI payments due to mental illness; or

d. the person maintains or could maintain a living arrangement only with the ongoing supervision and assistance of family or a public agency.

In July of 1988, the community mental health centers reported that a total of 2,175 people meeting this definition were being served in state funded community mental health programs in Montana.

Services required by persons with severe, disabling mental illness include, but are not limited to, mental health treatment, rehabilitation, residential care, peer support, and protection and advocacy. The Department must assure reasonable availability of these and other service components by purchasing services from community mental health centers and/or through agreements with other agencies. The major service components of Montana's community support system for adults with severe disabling mental illness is outlined in **Appendix B**.

The components of a community support system for persons with severe mental illnesses must be coordinated by case managers. Perhaps the single most important function of the mental health service system is the provision of case management to assist persons with severe mental illnesses in obtaining the services they want and need. A case manager may provide nothing more than a supportive relationship to an individual who chooses to be basically independent of the mental health system. In other instances, the case manager is actively involved in providing, arranging and advocating for a variety of services and supports from a variety of local agencies on behalf of the consumer.

In August of 1988, the Department began funding, on a limited basis, intensive case management services for adults with severe and disabling mental illness who are homeless or at risk of becoming homeless.

The Department defines "intensive case management" as: the activities of a single person or team which carries responsibility for: a) helping the consumer make informed choices about opportunities and services, b) assuring timely access to needed assistance, c) providing opportunities and encouragement for self-help activities, d) assisting the consumer in the development of realistic, attainable life goals, and e) coordinating all services to meet these goals. Intensive case

management is a supportive community-based service which seeks to maximize an individual's personal abilities and enable growth in some or all aspects of the person's vocational, residential, social, and health related environments. Priority is placed on providing personal support and guidance in helping the person acquire comprehensive, integrated resources in his or her natural community environment.

As reported by providers and consumers, this program is successful and the need for additional intensive case management staff is among the highest priorities identified through the planning process. The development of strong case management services will move the mental health system away from its traditional facility-based configuration. Prior to the implementation of intensive case management, programs were centered in day treatment and transitional living facilities. Consumers who were reluctant to attend a formal program often were not served.

The Montana State Hospital, the Department and the community mental health centers have attempted to develop interagency cooperation and continuity of services through an Admission and Discharge Review Team (ADRT). The ADRT includes representatives from the State Hospital, the Mental Health Bureau, and each mental health center. At its quarterly meetings ADRT discusses:

a) inappropriate admissions
b) problematic discharge planning
c) new programs
d) policy and procedure changes or recommendations for changes

These meetings also afford an opportunity for mental health center staff to become acquainted with the Hospital, its staff, and the needs of patients from each center's catchment area. Since the establishment of ADRT, the relationship between the centers and the State Hospital has improved and the continuity of care provided to persons with disabling mental illness has been enhanced.

A Community Mental Health Needs Survey, conducted in October, 1988, found that respondents placed a high priority on the following issues for improving services for adults with severe disabling mental illness:

1. Additional intensive case managers;
2. Crisis intervention services to avoid the use of jails;
3. Prompt follow-up of persons discharged from the State Hospital;
4. Additional residential options.

II.2 Children and Adolescents

The Department's role in the children and adolescent mental health system is one of purchasing community treatment services. Services are purchased in consultation and coordination with the Department of Family Services, which is Montana's lead agency for children's services.

The Department has a primary responsibility to advocate for and purchase intensive community services for severely emotionally disturbed children and youth. The National Institute of Mental Health has suggested that the term "severely emotionally disturbed children and adolescents" be used to describe young people with a diagnosed mental disorder who have substantial limitations in major life activities, have needs which can be met only through the efforts of more than one agency, and have had the disability over an extended period of time. These services may include crisis intervention, day treatment and various forms of residential support and therapy provided as an alternative to, or following discharge from, hospitalization and/or institutional treatment.

The Department has traditionally taken the position that although its primary role in purchasing services for children and adolescents is to meet the needs of the severely emotionally disturbed, early intervention with young people is also a state responsibility. The Department, therefore, funds outpatient services for children and youth who due to abuse, neglect or other traumas are in danger of becoming emotionally disturbed. For these children as well as for those who are emotionally disturbed, involvement of the entire family in treatment is often desirable.

Although the Department is the state mental health authority, the Department of Family Services has responsibility for most child and adolescent services. It is imperative that the two departments work together in setting priorities for the provision of state funded mental health services. The goal of this

collaboration is to coordinate mental health and family services programs in a way which will avoid duplication and will meet the mental health needs of children and youth to the maximum extent possible.

How to best provide services to emotionally disturbed youth has perplexed both public and private service providers for many years. Little if any agreement has existed on the definition of emotional disturbance. Rather than a diagnostic term with a well recognized and agreed upon symptomology, "emotional disturbance" is a program-linked concept. To an educator, an emotionally disturbed youth is one who has problems in school. To a mental health worker, it is a youth who displays psychological or behavioral abnormalities, and to a youth court worker, it is a youth who has chronically broken the law. This has led to considerable disagreement and confusion and a general lack of action to address the service needs of these youth. However, there is an increasing awareness that emotionally disturbed youth have multiple needs requiring different levels of intervention from a variety of service providers.

Another issue is the number of emotionally disturbed youth in the state of Montana. Although attempts to quantify the number were initiated approximately ten years ago, little or no success has been achieved. As was discussed above, there is little agreement between various disciplines having contact with youth regarding a definitive description of an emotional disturbance. The most reliable "count" comes from the Office of Public Instruction which annually surveys the school districts for this and other information. The problem with these data, however, is that they do not account for preschool age children, dropouts, or those children often described as quietly disturbed who do not provoke enough disruption in the system to gain a label of emotionally disturbed.

Studies conducted nationally suggest that approximately 11.8% of the total youth population experience a "clinical maladjustment". From a review of existing prevalence research, Knitzer (1982) in her book Unclaimed Children concluded "that a conservative estimate of serious emotional disturbance in children is 5% or approximately three million youngsters (nationally) ... it should be kept in mind that this 5% estimate includes only youngsters whose problems are severe and persistent, while the 11.8% estimate includes all emotionally disturbed youngsters."

For Montana, these estimates suggest that 30,668 youth experience some degree of emotional disturbance, with approximately 13,000 being severely emotionally disturbed. If these figures represent a fair estimate of the prevalence of emotional disturbance, then children and youth comprise a very underserved population in this State. Currently, there is no system in Montana for determining an unduplicated count of emotionally disturbed children, and what little data does exist falls far below the national estimates.

Based on the recommendation of a study group established to examine interdepartmental responsibilities, the Department of Family Services was designated as the lead agency providing direction to a collaborative effort to identify, and provide services to, emotionally disturbed youth.

Current Situation Regarding Services/Needs

In terms of an overview of the treatment system in Montana, comprehensive and integrated evaluation services are not consistently available statewide. Some community mental health centers provide excellent evaluations and some of these are coordinated with the school system. Other mental health centers do not have specific programs for evaluation of children and adolescents. In many rural areas, evaluations of emotionally disturbed children and adolescents are specific to education and do not include clinical assessments.

Individual, family and group psychotherapy by professionals trained specifically to work with children and adolescents is inadequate due to a shortage of trained professionals. This deficit is exacerbated by a lack of funding, communication, and coordination between service providers.

Day treatment programs to prevent institutionalization of children and adolescents are limited to only three communities. Availability of therapeutic group and foster home care is also extremely limited.

Acute care psychiatric hospital services for children and adolescents are available in several cities. These hospitals provide comprehensive and integrated evaluations as well as short-term care. General hospitals or adult

psychiatric facilities and programs are not appropriate for longer-term treatment, and residential treatment programs for children exist at only two locations in the state.

In-home therapeutic intervention, family teaching, and prevention/early intervention (ages 0 to 5) are among those services that are virtually non-existent, but which have been identified as priorities for development and funding. For another perspective on the currently available resources for children and adolescents, refer to **Appendices C.1 and C.2.**

In summary, more emotionally disturbed children need services than can be served with currently available resources. The first priority in efforts to improve and complete Montana's service system for emotionally disturbed children and adolescents is coordination of services. On both state and local levels the development of improved cooperation among mental health, education, social services, and juvenile justice agencies is necessary to ensure the development and funding of appropriate services.

II.3 Elderly People with Mental Health Problems

While elderly people with mental illness are in many ways similar to other mentally ill people, there are several features regarding the population that need to be noted:

1. The elderly are the fastest growing segment of our population and they have a higher incidence of mental health problems than the population at large.

2. The elderly receive a smaller share of mental health services than would be expected based on population statistics alone (both nationally and in Montana).

3. Of those over age 60 seeking services from community mental health centers in Montana, "affective disorders" are by far the most common diagnosis (30%), followed by "other non-psychotic disorders" (19%),

"schizophrenia and related disorders" (14%), and "organic disorders not alcohol or drug related" (12%).

4. As a group the elderly frequently must deal with severe disrupting losses (spouse, productivity, income, independence, home, family supports, etc.), many of which are permanent in nature. Such losses frequently cause severe stress which can lead to depression.

5. It is often noted that the elderly are particularly reluctant to seek out help, especially in the area of mental health.

6. Nationally, the elderly (60 years and older) constitute approximately 12% of the population. In 1982, they comprised only 6% of the total CMHC caseload nationally, despite estimates that from 15 to 25% of the elderly have significant mental health problems.

For purposes of this Plan, "elderly people with mental health problems" include all people 65 and older who have significant mental health problems. Given the high frequency of mental health problems among elderly people and the relatively low frequency of service, it is clear that the elderly have many unmet service needs. In a recently completed Montana Community Mental Health Needs Survey, the following items were most frequently identified as top priorities for service development for the elderly:

- Case management services for mentally ill elderly living at home.

- Effective linkages/agreements with aging services, chemical dependency programs and health care agencies to provide information, referral and improved service coordination.

- Local systems to identify elderly people in need of mental health services and health care assistance.

- In home therapy services for the elderly.

- In home multi-agency service teams.

It is notable that four of the five preceding needs clearly involve not only mental health providers but also the cooperation and participation of agencies or individuals typically regarded as being "outside" the mental health system. This has obvious implications for reaching beyond the notion of "typical" mental health providers in the planning, development and implementation of effective and accessible services. While the above issues have been identified as important for development, it should be pointed out that the Department will continue to promote the utilization of current CMHC services by elderly people with mental health problems.

II.4 Minorities with Mental Health Problems

Subgroups included in our consideration of "minorities with mental health problems" include cultural and ethnic minorities and those with unique problems caused by physical disabilities, such as deafness.

Ethnic and racial minority populations in Montana are relatively small. Native Americans are by far the largest group comprising approximately 4.6% of the state's population (2.9% on reservations and 1.7% off reservations). Other minority groups and their percentages of the state population are: Hispanics, 1.2%; Asians, .4%; and Blacks, .2%. Little quantified information is available on minority mental health problems in Montana and, because of low populations, the percentages of mental health services going to minorities is minimal. Comparison figures showing percent of state population, (first figure) and percent of CMHC admissions, (second figure) are as follows: Native Americans, 4.6% to 6.1%; Hispanics, 1.2% to 1.0%; Asians, 0.4% to 0.1%; and Blacks, 0.2% to 0.6%.

While the small populations reduce the actual demand for mental health services, the alienation, depression, and anger related to prejudice, discrimination, and poverty may place ethnic minorities at a high risk for mental health problems. These and other problems underscore the need for culturally appropriate and accessible community mental health services.

The recently completed Community Mental Health Needs Survey identified the following two items as top priorities for service development relative to

minorities: require staff training regarding culturally sensitive mental health services for minorities; and fund special outreach activities to identify minorities with severe mental disabilities.

While it is probably not feasible to develop programs or services that are specifically geared to the special or unique characteristics of all ethnic, racial, or other minorities, it may be possible to identify concentrations of populations within small geographic regions. Such identification would allow more effective outreach and identification of those with mental health problems, and more effective training to enhance cultural awareness and sensitivity among mental health staff.

II.5 Homeless Mentally Ill

For purposes of this Plan, we are using the following "Stewart B. McKinney" definition of homeless individuals:

1. An individual who lacks a fixed, regular, and adequate nighttime residence, or

2. An individual who has a primary nighttime residence that is:

   a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

   b) an institution that provides a temporary residence for individuals intended to be institutionalized; or

   c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

A number of variables influence whether a mentally ill person is also homeless. This is a multi-need group experiencing poverty, personal and family problems, and substance abuse, as well as possessing minimal social skills.

Though the number of Montanans who are homeless appears to be small (for example, 100 persons a year in Great Falls), problems exist in successfully and effectively providing services to this population.

A statewide survey of shelter facilities in Billings, Butte, Great Falls, Helena and Missoula produced an estimated rate of 25% to 30% of service recipients experiencing severe mental illness. These figures are in the range reported by other states. The shelter facility personnel were all aware of and made reference to community mental health services. The lack of stable living situations contributed to the perception that effective intervention with the homeless is difficult. In particular, for example, medication management was reported to be infrequently maintained. The shelter care providers tended to hold the perception that the homeless mentally ill frequently agree to mental health services, but do not (or are not able to) take advantage of the available services. As a consequence, the shelter managers did not see much change in the population.

In addition, the shelter providers expressed concern that more attention needed to be given to housing arrangements in discharge planning from the state hospital. All respondents preferred community solutions and understood the move to deinstitutionalization, but saw the lack of stable housing as exacerbating the symptoms of mental illness of some patients being discharged.

There was general agreement that there are relatively few homeless families. It was estimated that perhaps 5% of the total population who received services from shelters were currently "living" with one or more family members. Though severe and disabling mental illness symptoms were not prevalent, these families were described as exhibiting a restlessness or inability to settle down. However, the number of families in shelters was perceived to decrease during the time of year that school is in session.

Most shelter facility staff reported no need for specific training on dealing with the mentally ill except for skills relating to referral for mental health services and, particularly, for help in detecting the potentially violent person. The services most desired by shelters from mental health providers were

outreach and drop-in centers. Unless stability in housing can be introduced, the facility staff felt that not much lasting help can be provided to the homeless.

The Department has established contracts with each community mental health center utilizing a grant under the Stuart B. McKinney Act. It is the intent of these contracts that intensive case management services be provided to persons with severe disabling mental illness who are homeless or are subject to a significant probability of becoming homeless.

II.6 Adults, Ages 18-64, with Mental Health Problems

This is a diverse group of individuals with a variety of mental health needs. Although most might be functioning well socially and vocationally with some need of short term therapy, others may be experiencing emotional instability at a level where their ability to function in the workplace or social realm is marginal.

The therapeutic services used most often by this group are individual and group outpatient therapy and emergency services. The timely availability of these services for those individuals experiencing a crisis requiring intervention is an important component of the mental health system. Currently in some areas of the state people in need of outpatient services, other than emergency, are placed on a waiting list for four to six weeks before they can be served.

Emergency services by telephone, or face-to-face if needed, must be available 24 hours a day to those in crisis, especially for those who may be a danger to themselves or others.

Therapy services, either individual or group, may be needed for those individuals who are experiencing a personal trauma in their lives which has affected their ability to function at work, school, or home and which has the potential of disabling them further. Individuals who have been the victims of violence, those who are experiencing a difficult divorce or bereavement are examples of the type of life crisis that may require short term mental health services. Others may be experiencing an episode of serious mental illness for the first time and need help in dealing with the symptoms, as well as identifying

available treatment and services. The availability of these services in the public mental health system may be particularly important in the rural and remote areas of the state as these are areas in which private mental health providers are not likely to be found.

In addition to adults experiencing a need for emergency services and short term crisis intervention as described above, there are other adults in this population group who may require mental health services. Therapy programs for those with problems which may make them a danger to society, such as sexual offenders, are needed mental health services in the community.

Mentally ill individuals who are incarcerated may also be considered members of this group. Often mental health centers are called upon to evaluate individuals in the local jails to determine if they are mentally ill and if they are suicidal. The availability of these services is of particular concern in a number of areas of the state at the present time. The issue of an appropriate place, other than a jail, to retain persons suffering from mental illness who are involved with the correctional system is also a problem for local law enforcement officials in many communities.

Psychological evaluations of adult clients for other social service agencies is another service that is needed for this client group. Vocational Rehabilitation, the Department of Family Services and other agencies routinely request evaluations to determine the extent of impairment of clients seeking services from these agencies.

Although many clients in the group described above do not meet the Department's definition of persons with disabling mental disorders, a significant portion of mental health funds are spent to provide services to this group. Preliminary data recently collected on services provided to individuals within each of the priority groups defined by the Department (See **Appendix A**) indicate that greater than 40% of outpatient counseling services are provided to adults who do not have disabling mental disorders. The level of emergency services provided is approximately 40% of all emergency services and counseling services

for those requiring psychiatric inpatient care constitutes approximately 30% of inpatient services.

III. MONTANA MENTAL HEALTH SERVICE SYSTEM

III.1 Current Service System

Department Organization and Function

Within the Department, the Treatment Services Division has been delegated the responsibility for planning, organizing, and directing the state's mental health programs as well as other human service programs. The Division operates with two bureaus: the Chemical Dependency Bureau with the responsibility for the administration of chemical dependency services, and the Mental Health Bureau which provides administrative supervision and coordination for institutional and community programs for the mentally ill, institutional programs for the developmentally disabled, and residential nursing homes for veterans and elderly persons with chronic mental disorders. This Mental Health Plan primarily addresses community mental health services and their relationship to Montana State Hospital and the Center for the Aged.

Under authority defined by Section 53-21-202, MCA, the Department has the responsibility to:

1. Take cognizance of matters affecting the mental health of the citizens of the State;

2. Initiate preventive mental health activities of the statewide mental health programs, including but not limited to the implementation of mental health care and treatment, prevention, and research as can best be accomplished by community centered services. Such means shall be utilized to initiate and operate these services in cooperation with local agencies as established under this part.

3. Make scientific and medical research investigations relative to the incidence, cause, prevention, treatment, and care of the mentally ill*;

4. Collect and disseminate information relating to mental health;

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* The Department has never been funded to conduct scientific and medical research

5. Prepare and maintain a comprehensive plan for the development of public mental health services in the state. The public mental health services shall include but not be limited to community comprehensive mental health centers, mental health clinics, traveling service units, and consultative and educational services;

6. Provide by regulations for the examination of persons who apply for examination or who are admitted either as inpatients or outpatients to the Montana State Hospital or other public mental health facilities;

7. Receive from agencies of the United States and other state agencies, persons or groups of persons, associations, firms, or corporations grants of money, receipts from fees, gifts, supplies, materials, and contributions for the development of mental health services within the state;

8. Establish standards for public mental health facilities;

9. Evaluate performance of public mental health facilities in compliance with federal and state standards.

Federal law requires the participation of a state Mental Health Council in the mental health planning process. The Department recognizes the appropriateness of that requirement and has, with the cooperation and approval of the Governor, established the Montana Mental Health Advisory Council. The Council is comprised of ten members and is appointed every two years. Membership includes individuals representing consumers, mental health professionals, interest/advocacy groups, service provider agencies, state government, the state legislature, and others. The Council's membership will be expanded in FY 1989 to ensure compliance with the new ADMS Block Grant amendments as required by PL 100-690, 1916(f) of the PHS Act. The Council meets at least quarterly to review and recommend policy, evaluate program activities, and recommend priorities for action and expenditures. (See **Appendix D**, List of Council Members).

Responsibility for all functional activities carried out under the Mental Health Plan rests with the Department staff, with final authority from the Director of the Department. The following is a brief description of Mental Health Bureau functions.

Standards, Evaluation and Certification

The Department is required by statute (Section 53-21-202, MCA,) to set standards for community mental health centers. The Department does not set program standards for other providers unless the Department chooses to purchase services from the agency. The Mental Health Bureau annually conducts on-site reviews of the community mental health centers to evaluate treatment programs, clinical records, staff qualifications, and data collection systems. The purpose of the evaluation procedure is to ensure that the centers are complying with state and federal standards and contract requirements.

The Bureau is responsible for administering a professional person certification program. This includes establishing qualifications for certification (20.14.501-512, ARM) and conducting evaluations of credentials of persons requesting certification as mental health professional persons.

Another agency which conducts evaluation and review of mental health facilities, and which is independent of the Department, is the Mental Disabilities Board of Visitors. The Board of Visitors is a five member board, attached to the Governor's office, established to assure that the treatment of all persons admitted to a mental health facility is humane and competently provided. The Board employs attorneys who provide legal services to patients at the Montana State Hospital. The Board, with assistance of clinical consultants, annually conducts on-site reviews of the Montana State Hospital, Center for the Aged, the five regional mental health centers and Rivendell of Billings. The Board does not review other mental health facilities on a regular basis, although the Board can review other programs if there is a complaint about the treatment of patients.

Planning and Management Information Systems

State and federal law require the Department, with advice and recommendations from the State Mental Health Advisory Council, to prepare and maintain a comprehensive plan for mental health services for the State of Montana. The development of the Plan is a systematic series of activities which include: (1) data gathering, needs assessment, and a problem identification

process; (2) prioritization of needs and the development of action strategies; and (3) development of a draft plan which includes goals and quantitative objectives to implement action strategies which may address modification or expansion of mental health services. The primary focus of this FY 1990-93 State Plan is to define the future planning process, outline realistic approaches and timelines, identify planning resources and key participants and set a direction for the mental health system.

The planning process for the FY 1990-1993 Montana Mental Health Plan has included the following activities:

1. Development by Mental Health Bureau staff of preliminary planning issues. Identification of these issues was accomplished by review of client and fiscal data, program evaluation results and input from providers, consumers, and interested citizens.

2. A Montana Community Mental Health Survey was sent to nearly 400 Montanans. The survey asked respondents to indicate the availability and adequacy of mental health services in their own communities and to prioritize statewide issues relating to enhanced services. **Appendix M** shows how the 200 people who responded prioritized the issues related to each of six population groups.

3. Organizations and agencies serving, representing or advocating for people with mental illness were surveyed to identify planning issues, legislation or policy initiatives these agencies were undertaking.

4. Shelters for the homeless were surveyed to identify the extent of mental illness among the homeless and how the community mental health system could assist the homeless mentally ill.

5. Public forums were held in three communities to gather suggestions and recommendations from interested citizens. The newspaper advertisements which announced the forums also included the Mental Health Bureau's address for persons preferring to provide written input.

6. The Mental Health Advisory Council, with the assistance of a consultant facilitator reviewed the issues which were surfaced through the five steps outlined above and made recommendations about the relative priority of each issue. That prioritization is shown in **Appendix N.**

7. Based on steps 1-6, Department staff developed a draft plan which was distributed widely for comment.

8. Five public forums were held to receive input from interested citizens. In addition, written comments were solicited.*

9. The Mental Health Advisory Council reviewed the draft Plan and the comments on the Plan and made recommendations for changes.*

10. The final Montana Mental Health Plan for FY 1990-1993 was published and distributed.*

The planning process is ongoing. **Appendix E** shows the annual planning cycle. A major planning effort has been conducted in FY 1989 to develop the FY 1990-1993 State Plan. Abbreviated planning updates will be completed in FY 1990 and 1991 with another major effort occurring in FY 1992 to develop the FY 1994-97 Plan. After FY 1992, major efforts need only be done every four years with abbreviated updates in other years as shown below:

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* Explanatory note: Items #8, #9 and #10 above, were not completed when the draft plan was distributed. Time frames call for April/May distribution of final plan.

Planning Timeframe	Executive Planning Process	Legislative Years	Planning Update	Fiscal Year Covered
Aug 88 - Apr 89		X	Major	90-93
Aug 89 - Apr 90	X		Abbreviated	91-93
Aug 90 - Apr 91		X	Abbreviated	92-93
Aug 91 - Apr 92	X		Major	94-97
Aug 92 - Apr 93		X	Abbreviated	95-97
Aug 93 - Apr 94	X		Abbreviated	96-97
Aug 94 - Apr 95		X	Abbreviated	97
Aug 95 - Apr 96	X		Major	98-01

Fiscal, client and service data which document the purchase of mental health services in the community are collected by the Mental Health Bureau and are reviewed and evaluated at least quarterly. With the assistance of service providers, a major effort will be continued in FY 1990 to develop and enhance data gathering systems for the development of better information for planning and contract monitoring.

Resource Allocation and Contract Management

Since 1982, contracts with Community Mental Health Centers have been based on a fee for service system. A standard per unit cost for each service category is calculated based on annual cost information provided by each Center. Contracts are then developed which purchase a specific number of units of service in each service category with the number of units based on the level of services provided by the Center the previous year and Department priorities. With funding levels inadequate to purchase all services provided by the Centers, two contracting mechanisms ensure that seriously mentally ill individuals receive needed services. First, services which are normally provided to clients with disabling mental illness, e.g. day treatment, transitional living, emergency and inpatient services are considered priority services and all units of services provided are purchased with state funds. Other services, primarily outpatient counseling services, are purchased at a level less than 100%. Second, a limitation is placed on who is eligible for state purchased services. A Functional Assessment Scale is utilized to evaluate the clients level of functioning and only those who are determined to be functioning at a level of 6 or below (on a scale of 9) are eligible for state funded services.

In FY 1989, a number of modifications to the purchase of services system were implemented.

1. A definition of severe and disabling mental illness was adopted by the Department and priority groups for mental health services were established. (See **Appendix A**)

2. Intensive case management services are reimbursed as a separate service. Using population as a basis, centers are allocated a specific number of FTE for case managers and reimbursement is based on the number of case managers in the region. This removed the disincentive to provide case management services which do not involve face to face client contact -- the basis of the fee-for-service system.

3. Telephone emergency services are no longer reimbursed based on units of service. A specific amount is granted to each center to ensure availability of emergency services and reimbursement level is not dependent on the units of service provided in this category.

4. The method to determine the reimbursable cost per unit was modified to recognize the level of reimbursement from other sources, i.e. insurance and first party payments. Whereas previously, reimbursement rates were based on the full cost of providing the service, rates now are reduced to reflect an anticipated level of reimbursement from other sources. This method more accurately focuses public money to purchase services for individuals who are financially unable to pay for services.

5. Adjustments were made to the reimbursement rates to reflect the higher costs of providing services in rural areas. An analysis of costs in rural counties showed that services in these areas were approximately 20% higher than in more urban areas. Thus those centers providing a high percentage of rural services were being penalized with a standard reimbursement rate. The new methodology adjusts the unit rate for outpatient services in each center based on the proportion of services provided in rural counties.

The changes already implemented have moved the Department in the direction of meeting its goals of serving those mentally ill persons most in need of service, and developing a system that allocates funds equitably to all mental health regions in the state. However, a number of problems continue to exist and further changes will be evaluated. A specific area of concern is development of a method of reimbursing mental health centers that will provide an incentive for serving seriously mentally ill people in community settings rather than the state hospital.

Human Resource Development and Community Support Projects

The Department has a grant from the National Institute of Mental Health (NIMH) to develop the state's capacity for Human Resource Development (HRD) including an HRD plan which will address mental health workforce problems and develop strategies for solutions. The Plan will deal with staff planning and training, the availability of a competent workforce, and resource allocation issues. This project was authorized for FY 1988 and 1989 and the Plan will become part of the FY 1990-93 Plan updated in the fall of 1989. A description of the HRD planning issues which have been identified is included here as **Appendix F.**

Also in FY 1988, the Department was awarded a Community Support Program (CSP) System Improvement Project grant from the NIMH. This is a three year project designed to strengthen the consumer movement in Montana by providing financial assistance to the Montana Alliance for the Mentally Ill to enhance that organization's ability to provide support and advocacy for persons who are mentally ill. The project is also intended to strengthen the skills and knowledge of staff who work in CSP treatment programs. The project will focus on the roles and responsibilities of various agencies and organizations which provide services and advocacy for persons with severe and disabling mental illness. Copies of the HRD and CSP grants are maintained at the Mental Health Bureau and are available upon request.

Federal Liaison, Coordination and Institutional Assistance

The Department serves as the agent of the State executive branch in communicating with federal agencies and administering federal mental health funds including the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant. Federal funds are allocated by the Department based on state and federal priorities. The Mental Health Bureau communicates and coordinates with the federal government regarding issues affecting mental health services. The Bureau continually pursues federal funding opportunities and assists local agencies in applying for federal funds.

The Department will continually improve coordination among state agencies for certain aspects of the total mental health delivery system in Montana. The Department will work closely with the Department of Family Services toward ensuring quality mental health services for children and adolescents. Coordination with the Department of Health and Environmental Sciences is needed on such issues as the Certificate of Need process, licensure and inspection requirements for mental health facilities, and the flow of ideas and information in support of both agencies' planning processes. Coordination with the Department of Social and Rehabilitation Services is needed to address services provided under Medicaid and the vocational rehabilitation program as well as services for those with dual diagnoses of mental illness/mental retardation. The Department will continue to cooperate with the Board of Visitors in support of its quality assurance and advocacy efforts consistent with Section 53-21-104, MCA. The Department will also work with the higher education system to facilitate an increase in the availability of education and training opportunities which are specifically relevant to services for priority populations as established in the Montana Mental Health Plan; and with the Office of Public Instruction on sharing information and identifying issues and possible strategies for mental health services to children and youth.

Prevention and Early Intervention Services

The Department views its primary mission to be the provision and purchase of services for people who have mental illnesses which substantially impair the functioning of the individual. Preventative and early intervention services

are, however, also important and the Department provides some funding for these activities while attempting to fulfill its primary mission.

Not enough is currently known about the causes of the major mental illnesses to successfully prevent those diseases. Behavior problems and conduct disorders in children, on the other hand, can probably be prevented through the promotion of effective child rearing practices. Secondary prevention, through early intervention, can mitigate the disabling effects not only of major mental illnesses but also of childhood behavior disorders and emotional distress caused by traumatic situational factors.

Department contracts with community mental health centers encourage early intervention services for children by not requiring that clients younger than 18 meet any functioning level criterion in order to receive Department funded services. The Department also contracts with an agency in Missoula (Friends to Youth) which serves youth and their families exclusively. Friends to Youth emphasizes aggressive outreach and advocacy approaches to serving adolescents.

In addition to the early intervention services made available to children and adolescents, the Department reserves a small amount of money for prevention activities which are not tied directly to client services. Each year the Department has distributed approximately $60,000 among the five regional mental health centers to pay for any of a variety of consultation and education services.

FY 1988 and 1989 Budget

Appropriations for community mental health services and state level administration are $5,468,673 for FY 1988 and $5,891,925 for FY 1989. In each year of the biennium, $5,116,391 is line itemed for purchasing community services with state and ADMS Block Grant funds. During FY 1988, the Department received $14,616 from the HRD Grant and $8,453 from the CSP Grant. Both grants have been authorized by budget amendment for fiscal years 1988 and 1989. The Department applied for and received $275,000 under a Federal Homeless Block Grant for FY 1988 and is anticipating $268,000 in FY 1989. The Department also received an additional $82,200 with the passage of PL 99-660 to implement the state mental

health planning process. These funds will assist the Department in carrying out its planning activities.

FY 1988 AND 1989 APPROPRIATION

Expenditures	Actual FY 1988	Budgeted FY 1989
Personal Services	$ 179,663	185,368
Operating Expenses	85,313	56,987
Purchase of Service:	5,112,497	5,116,391
HRD	14,616	83,037
CSP	8,453	92,942
Homeless	0	275,000
Planning	0	82,200
Total Costs	$5,400,542	$5,891,925
Revenue		
General Fund	4,104,599	4,108,940
Federal Funds	1,295,943	1,782,985
Total Funding	$5,400,542	$5,891,925

State Institutions and Other Inpatient Services

In addition to the community based programs which are operated by private, nonprofit corporations, the public mental health system includes Montana State Hospital and the Montana Center for the Aged. The former Montana Youth Treatment Center is listed under the name of its current owner, Rivendell of Billings.

Montana State Hospital

Montana State Hospital consists of campuses at Warm Springs and Galen, approximately four miles apart.

The mission of Montana State Hospital is defined by State law (Section 53-6-301, MCA):

"(a) care and treatment of mentally ill persons;

(b) diagnosis, care, evaluation, treatment, referral, and rehabilitation of persons afflicted with chemical dependency;

(c) care and treatment of institutional residents or clients of the department's community and residential programs who require acute hospital care or nursing care;

(d) treatment of tuberculosis and silicosis (commonly called miner's consumption);

(e) detoxification of those persons who seek relief from the disabling effects of alcohol and other chemical substances; and,

(f) contingent upon space and funds, the treatment of pulmonary diseases and other medical or organic disorders."

The Warm Springs campus is designated as the adult state mental health facility and provides inpatient psychiatric treatment for those mentally ill adult Montanans who cannot effectively be served in existing community based alternatives. The Warm Springs facility had an average daily population of 288 in FY 1988.

The Galen campus provides residential treatment for persons suffering from chemical dependency; acute hospital care for patients from both Montana State Hospital campuses; and intermediate nursing care for mentally ill individuals who require nursing services. During FY 1988, the Galen facility had an average daily population of 178.

A major emphasis of the mental health planning process will be to continually evaluate Montana State Hospital patients to determine if they could be better served in community settings. An ongoing review and revision of mental health commitment laws, hospital admissions and operational policy could make it possible to reduce the size of the hospital to a point where funds could be transferred to community services. However, implementation of the 1987 Omnibus Budget Reconciliation Act (OBRA) for nursing home reform could have a major impact on the population of the Montana State Hospital in FY 1990-93.

Appendices G and H show cost data for Montana State Hospital units and a breakdown, by diagnostic category, of the Warm Springs campus caseload. Admissions by county for a two year period are shown in **Appendix L.**

Montana Center for the Aged

The Center is located in central Montana at Lewistown. As defined in the Administrative Rules of Montana [20.14.104(1)],

> "the Montana Center for the Aged is a licensed residential facility for the long term care and treatment of persons 55 years of age or older who have chronic mental disorders associated with the aging process and who require a level of care not available in the community, but who cannot benefit from the intensive psychiatric treatment available at Montana State Hospital. The Center is not established as a transitional mental health facility because of the chronic nature of its residents' mental disorders. However, the Center may discharge residents who can function in, or benefit from, community settings."

The Center had an average daily population of 174 in FY 1988. Ages range from 55 to 97 years, with a mean age of 75 years. The 1987 OBRA nursing home reform may also impact this institution's future population.

FY 1988 expenditures for the Center for the Aged were as follows:

Personal Services	$2,126,339
Operations	496,020
Equipment	433
Total Expenditures	$2,622,792

Rivendell of Billings

The Department no longer operates a facility which provides psychiatric inpatient services to individuals under the age of 18. The former Montana Youth Treatment Center was sold to Rivendell of Billings, effective January 1, 1987. Although this facility is now privately operated, it must by law admit and treat

up to 40 court ordered adolescents. Other private inpatient facilities may admit court ordered patients, but they may also refuse. Rivendell of Billings cannot refuse admission to a court ordered patient unless 40 court ordered patients are present at the time. This facility is subject to annual review by the Board of Visitors. Although this facility provides short term in-hospital services for emotionally disturbed children, Montana is lacking in long term intensive services. A major effort in FY 1990-1993 will be to develop community-based long term services for emotionally disturbed children.

Community Mental Health System

The Montana community mental health system is made up of a variety of local agencies as well as independent private practitioners and short term psychiatric inpatient units. Virtually all of the Department's community mental health funds are used to purchase services from five regional mental health centers. These centers are established by state law (Title 53, Chapter 21, Part 2, MCA) as private nonprofit organizations. Each center serves a multi-county region and each participating county commission appoints one person to the Center's board.

By law (Section 53-21-201(2), MCA) a "community comprehensive mental health center" offers six basic mental health services to the public: "(a) 24 hour inpatient care at a licensed hospital; (b) part-time hospitalization, (c) outpatient services; (d) emergency services; (e) consultation and education in mental health; (f) precare and aftercare." Shown below are total revenues of community mental health centers in FY 1988 by funding source. Revenue figures in this section were taken from community mental health center audits which report revenues on an accrual basis.

Patient Fees (1st and 3rd Party)	$ 2,029,612	16.79%
Medicaid/Medicare/State Medical	2,990,323	24.74%
Dept. of Institutions Contract	5,072,710	41.96%
Other Agency Contracts	636,919	5.27%
County Contributions	865,940	7.16%
Other	493,403	4.08%
Total Revenue	$ 12,088,907	100.00%

Prior to FY 1982, community mental health centers received state and federal funding separately. Categorical mental health grants were received by the Centers directly from the federal government. State funding was received through

a block grant method which did not tie funds to specific quantities of patient services.

Since FY 1982, the Department has purchased services from the Centers under a fee-for-service contracting mechanism. The Department pays the Center set fees for each client-hour (or client-day for residential service) provided. The Department has encouraged the provision of services to certain client groups (such as to people with severe mental illnesses) by placing a high priority upon the purchase of the types of services typically needed by members of those client groups. Federal mental health block grant monies are received by the Department and are included, with state general funds, in the fee-for-service agreements.

The following are brief descriptions of the five centers (see **Appendix I**, Map of Mental Health Regions) and revenues by funding source for FY 1988. Client admission and caseload data for each region are displayed in **Appendices J and K**. This information was taken from monthly data submitted to the Department by the centers.

Region I - Eastern Montana Community Mental Health Center

The Eastern Montana Community Mental Health Center headquartered in Miles City serves a catchment area consisting of seventeen counties in Eastern Montana. The mental health center operates full-time clinical offices in eight communities and staff travel to other communities to provide part time services. There is a transitional living facility operated by the Center in Miles City and adult day treatment programs in Miles City, Glendive and Sidney. Shown below are the total revenues of the Center, by source, for FY 1988 (July 1, 1987 - June 30, 1988).

Patient Fees (1st and 3rd Party)	$ 251,742	15.60%
Medicaid/Medicare/State Medical	241,469	14.97%
Dept. of Institutions Contract	793,963	49.21%
Other Agency Contracts	160,516	9.95%
County Contributions	155,141	9.62%
Other	10,583	.65%
Total Revenue	$1,613,414	100.00%

Department funding of this Center is projected to be $777,959 in FY 1989.

Region II - Golden Triangle Community Mental Health Center

The Golden Triangle Community Mental Health Center, headquartered in Great Falls, serves nine counties in north central Montana. The Center operates a major alternative services program for adults with severe mental illness in Great Falls. This program includes a day treatment program, three transitional living facilities, intensive case management, and a supported employment program. There also is an outpatient clinic and a newly established adolescent day treatment program in Great Falls. The Center has clinical offices in seven other Region II communities and a small day treatment program in Havre. This Center's FY 1988 revenues, by source, are shown below:

Patient Fees (1st and 3rd Party)	$ 401,924	15.20%
Medicaid/Medicare/State Medical	825,512	31.20%
Dept. of Institutions Contract	1,183,073	44.71%
Other Agency Contracts	3,938	.15%
County Contributions	164,938	6.23%
Other	66,586	2.51%
Total Revenue	$2,645,971	100.00%

Department funding of this Center is projected to be $1,282,716 in FY 1989.

Region III - Mental Health Center

An eleven county area in southcentral Montana is served by Mental Health Center, which is based in Billings. Mental Health Center operates full-time clinical offices in five communities and staff travel to several other communities to provide services on a part time basis. This Center has two adult day treatment programs and six residential programs in Billings. Mental Health Center FY 1988 revenues, by source, are shown below:

Patient Fees (1st and 3rd Party)	$ 528,030	18.35%
Medicaid/Medicare/State Medical	651,186	22.63%
Dept. of Institutions Contract	1,086,682	37.76%
Other Agency Contracts	82,745	2.88%
County Contributions	302,213	10.50%
Other	226,689	7.88%
Total Revenue	$2,877,545	100.00%

Department funding of this Center is projected to be $1,015,679 in FY 1989.

Region IV - Mental Health Services, Inc.

This Center, headquartered in Helena, serves a twelve county area in southwestern Montana. Mental Health Services, Inc., operates full-time clinical offices in five communities with staff traveling to other communities on a part-time basis. Major day treatment programs and residential services are available in both Helena and Butte, while a smaller adult day treatment program has been established in Livingston. The Center provides adolescent day treatment in Helena. Mental Health Services, Inc., revenues for FY 1988 are shown below:

Patient Fees (1st and 3rd Party)	$ 456,155	17.00%
Medicaid/Medicare/State Medical	675,355	25.17%
Dept. of Institutions Contract	866,505	32.30%
Other Agency Contracts	389,720	14.53%
County Contributions	132,130	4.93%
Other Sources	162,835	6.07%
Total Revenue	$2,682,700	100.00%

Funding for the Department for this Center is projected to be $1,001,223 in FY 1989.

Region V - Western Montana Community Mental Health Center

The Western Montana Community Mental Health Center, headquartered in Missoula, serves a seven county area. The Center has clinical services available on a full-time basis in six communities and a part time clinical office in one community. The Center provides day treatment and residential services for seriously mentally ill adults in both Kalispell and Missoula. The Center also contracts for residential services provided by an independent private nonprofit organization in Stevensville. FY 1988 revenues for this Center are shown below:

Patient Fees (1st and 3rd Party)	$ 391,761	17.26%
Medicaid/Medicare/State Medical	596,801	26.30%
Dept. of Institutions Contract	1,142,487	50.35%
Other Agency Contracts	0	.00%
County Contributions	111,518	4.91%
Other	26,710	1.18%
Total Revenue	$2,269,277	100.00%

Department funding for this Center is projected to be $1,261,221 in FY 1989.

Friends to Youth

In addition to contracting with the five mental health centers, the Department, as a result of past legislative action, continues to purchase services from a community program serving youth. Friends to Youth is a Missoula based private nonprofit agency which provides counseling, case management and advocacy to youth, ages 10-18, and their families. The program serves troubled youth whose problems range from situational problems and minor conduct disorders to serious emotional disturbances. Friends to Youth serves 200-250 youth per year.

Department funding of Friends to Youth is projected to be $39,784 in FY 1989.

Other Community Services

In addition to the agencies funded directly by the Department, there are many other agencies and individuals providing community based mental health services in Montana. There are inpatient psychiatric units in general hospitals located in Missoula, Butte, Helena, Great Falls, Billings, and Miles City. There is a free standing psychiatric hospital in Kalispell and a free standing hospital in Helena providing inpatient psychiatric care for emotionally disturbed children. Rivendell of Butte has recently began providing inpatient services for children and adolescents. The Department does not utilize its mental health funding to purchase inpatient services from these facilities. However, the Department may purchase the mental health services of community mental health center staff providing services to patients served in these facilities.

There is a system of foster care and residential programs, primarily affiliated with the Department of Family Services which serves a number of emotionally disturbed children. Private practitioners, including psychiatrists, licensed psychologists, licensed social workers, licensed counselors and psychiatric nurses, are also an important segment of the community mental health system.

III.2 Service System Problems

Any analysis of problems in the Montana mental health system must begin with the fact that there are not sufficient resources to adequately meet the need of all individuals who seek publicly financed mental health services.

Some service gaps such as inadequate numbers of intensive case managers for adults with severe and disabling mental illness, exist statewide. Others, such as unacceptable crisis intervention facilities are problems in a few communities. Service gaps include deficiencies in the statewide capacity of some services which are available (eg. day treatment for seriously emotionally disturbed children and adolescents) as well as the virtual unavailability of certain important service components, such as in-home therapy for seriously emotionally disturbed children.

It is easy, in a state like Montana which has had a number of years of economic problems, to point to a lack of resources to meet identified needs as the problem. Regardless of funding level, however, the Department must continually set and reevaluate priorities to use available resources as wisely as possible. The following problem areas affect the priorities which are set.

Rurality

Montana's population of 809,000 (1987 estimate) is dispersed among 147,000 square miles; the overall population density is about 5.5 people per square mile. Eastern Montana (mental health region 1) is particularly rural, having approximately 100,000 people in an area the size of the state of New York. The rural nature of Montana presents a challenge in making services reasonably accessible. It is not possible to provide a full array of services in every community. Developing a continuum in one community to serve residents of several other towns is also impossible because of the often great distances between communities. Clinical staff in small communities often consists of one therapist who must be prepared to serve a wide range of clientele including adults with chronic mental illnesses and emotionally disturbed children and youth. Finding staff with the necessary skills who choose to work in small remote communities is a major human resource challenge for Montana.

Service System Fragmentation

The public mental health system for children and youth consists not only of the community mental health programs but also of programs administered by the Department of Family Services (DFS), local education agencies, and youth court staff. The creation in 1987 of DFS has focused responsibility on that Department as Montana's lead children's services agency. There continues, however, to be a need for better agreement at state and local levels of each service system's responsibilities for serving emotionally disturbed children.

The service system for adults with severe and disabling mental illness is clearly the responsibility of the Department of Institutions and, as such, is not as fragmented as the system for children. However, increased coordination between the Montana State Hospital and the community mental health programs is needed. There should be mechanisms to assure local screening of potential State Hospital admissions in every community and to provide for prompt contact by the local mental health agency of patients discharged from the Hospital. It has been suggested that the current Hospital/community system does not provide sufficient incentives to serve patients in communities. A more unified mental health system which includes such incentives should be implemented.

Consumer Involvement

It has only been in the past three to four years that consumers have started to be heard in mental health policy discussions. The Montana Alliance for the Mentally Ill and the Mental Health Association of Montana increasingly provide input to planning and policy discussions which is independent of providers and the state agency. The system should encourage an increasing involvement of primary and secondary consumers individually and through these and other organizations. A major challenge is to stimulate the development of a strong advocacy organization for parents of emotionally disturbed children and adolescents.

Defining a System

For a number of years the Department of Institutions has attempted to improve services for persons with serious long-term mental illnesses by redirecting resources from other services. This has been done to meet real needs but it has not been done in pursuit of a clearly defined vision of what the mental health system should ultimately look like. It is in part as a result of this absence of a vision that there has been a longstanding debate over the role of state funded mental health services.

The Department has moved toward, but never fully implemented, a policy of using state funds only for children and for adults with several disabling mental illness. Others have argued that state funded services should be available to anyone who is unable to pay full fee-for-service, regardless of the severity of the person's problems. It is important that a vision of a service system for the Department priority groups be developed and, in doing so, that clear policy decisions be made concerning the system's responsibility for serving other groups.

IV. DESCRIPTION OF IDEAL SERVICE SYSTEM

IV.1 System for Children/Adolescents

With an acceptance of the overall philosophy that communities should accept responsibility for serving their children as close to home as possible, and that systems of care should be community-based, the following model seems to provide a helpful framework from which thinking, planning and action can be organized.

A "system of care" model, developed at the University of Florida through a project sponsored by CASSP with broad input from the field is designed to be a guide and is based on the best available empirical data and clinical experience to date. It represents more than a continuum of service components, and is defined as being ".....a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents who are severely emotionally disturbed and their families".

This "philosophy" represents the way in which services should be delivered to children and their families, and allows for the probability that the actual service components and organizational structure of the system of care may differ from state to state and from community to community. All systems of care can be guided by the basic values and operational philosophies contained in this model, however.

Central to the system of care model, and its operation, are two basic, essential values. The first value is that the system must be child-centered. That is, the focus is seen as a commitment to adapt services to the child and family rather than expecting them to conform to pre-existing service configurations. Resultantly, this model is also family-focused. The system commits to supporting parents as care givers through supportive services, education, and support.

The second essential value maintains that the system of care for emotionally disturbed children should be community-based. While institutional care may be appropriately indicated for certain children at certain times, in many instances

appropriate services can be provided in less restrictive settings within or close to the child's home community.

In terms of organization, the system of care model can be thought to consist of seven major dimensions:

1. Mental Health services
2. Social services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Operational services

Each of these dimensions represent an area of need for children and their families, a set of functions that must be fulfilled in order to provide comprehensive services to meet these needs. It should be noted, however, that the model does <u>not</u> specify which type of agency should fulfill any of the particular functions or needs. The system of care model is function-specific rather than agency-specific.

Another important aspect of the concept of a system of care is the notion that all components of the system are interrelated and that the effectiveness of any one component is related to the availability and effectiveness of all other components -- not only the components within a service dimension, but all of the seven service dimensions that comprise the model.

In summary, the system of care model briefly outlined above will serve as a helpful framework in our assessment of the current service system in Montana, as well as in planning improvements. What configuration it might take on here is still unknown. Essentially, we are at the preliminary step of establishing interagency coordination and cooperation on both the state and local levels. While there is interagency agreement on the potential usefulness of the "system of care" model, actual initiation of planning has yet to occur.

IV.2 System for Adults with Severe and Disabling Mental Illness

The National Institute of Mental Health has described a mental health system for adults with severe and disabling mental illness as one which includes the following components:

1. Mental Health Treatment
2. Crisis Response Services
3. Health and Dental Care
4. Housing
5. Income Support and Entitlements
6. Peer Support
7. Family and Community Support
8. Rehabilitation Services
9. Protection and Advocacy
10. Client Identification and Outreach

The following describes Montana's current level of development in each of these areas. Quantities and locations of major service components are shown in **Appendix B.**

Mental Health Treatment

As described earlier, the publicly-funded community mental health system consists primarily of five regional community mental health centers. These centers have full or part-time clinic offices in 38 communities. Day treatment programs are located in 11 communities.

There are seven Montana hospitals which provide short term inpatient psychiatric care. These hospitals are not part of the public community mental health system but in most cases allow local mental health center staff to serve patients who are admitted for inpatient care. The Montana State Hospital provides inpatient care for patients who require longer term care which cannot be provided at the local level.

Crisis Response Services

Twenty-four hour crisis telephone services are provided in all communities served by the mental health centers. In some communities (e.g. Great Falls) local mental health centers, hospitals, and other agencies collaborate effectively to provide appropriate crisis intervention. In other communities the services are less well developed and, unfortunately, local jails are sometimes used to house mentally ill persons in crisis.

Health and Dental Care

It is an important role of mental health case managers to assist consumers in obtaining adequate medical and dental care. For indigent consumers, the Medicaid program funds these services. The Montana Medicaid program has chosen to include virtually every optional service allowed by the federal government.

Housing

Housing is provided by the community mental health system by Transitional Living I facilities. These are group homes (most have 8 beds) operated by community mental health centers and funded by state government. The mental health centers also provide Transitional Living II services which is essentially a supported independent living service purchased by the Department.

As the system strengthens and expands its case management capacity, it is anticipated that there will be greater emphasis upon providing needed support for consumers who are living independently rather than relying only upon group home services.

Income Support and Entitlements

In addition to Medicaid benefits discussed earlier, eligible clients receive SSI and SSDI benefits, Food Stamps, and/or General Assistance. An important responsibility of case managers is assistance in obtaining these benefits.

Peer Support

The growth of the Montana Alliance for the Mentally Ill (MonAMI) Consumer Council in recent years has increased the availability of peer support. Consideration must be given to organized consumer operated programs such as drop-in centers.

Family and Community Support

MonAMI actively provides family support through its 7 local chapters. In some communities (e.g. Kalispell) there is close collaboration between family support groups and local mental health center staff.

Community mental health centers provide education and support to agencies, employers, landlords, etc.. It is an especially important responsibility of intensive case managers to provide this type of support.

Rehabilitation Services

Several of the day treatment programs operated by community mental health centers provide psychosocial rehabilitation programming. All of the programs emphasize the development of social skills.

The Montana state vocational rehabilitation program funds a variety of vocational services for adults who are disabled by mental illness. Since 1987, supported employment services for the mentally ill have been initiated in 8 communities. For clients who do not qualify for vocational rehabilitation services, day treatment programs provide vocational services, including paid work options in several programs.

Protection and Advocacy

The Mental Disabilities Board of Visitors, which is described in Section III.1 of this Plan, provides protection and advocacy services. The Montana Advocacy Program (MAP) is the state's federally funded protection and advocacy agency. MAP provides for a full time mental health advocate who is available to

assist consumers who have difficulty with the service system. The Protection and Advocacy Advisory Council offers system-level input on behalf of consumers.

In discussing protection and advocacy, it should not be overlooked that the Department and the mental health service providers also have protection and advocacy roles to play. It is the Department's goal that, recognizing that there will always be differences in emphasis and priorities, the various components of the mental health system will work cooperatively to protect the rights of the clients served.

Client Identification and Outreach

With the initiation of intensive case management services, identification of mentally ill persons in need and outreach to those persons has been enhanced.

The key to making these services available for individual consumers is the existence of a strong system of case management. The Department has the clear responsibility to assure that case management services are available to help consumers select and gain access to the services they want and need.

The current Montana mental health systems includes all of the components listed above although the availability and adequacy of the components varies from community to community. With the assistance of the Mental Health Advisory Council and a mental health system consultant, the Department is moving toward a clearer definition of how these components can be fully developed on a statewide basis.

V. GOALS AND OBJECTIVES

The Department has adopted the following goals and objectives for the FY 1990-1993 Montana Mental Health Plan. Because many of the objectives involve analysis and further planning, virtually all of the anticipated completion dates are during the first two years of the four year period covered by the Plan. As the planning and analysis objectives set out below are accomplished specific program development objectives will be established as part of the annual Plan update process.

GOAL I: TO ENHANCE THE COMMUNITY SUPPORT SYSTEM FOR PEOPLE WITH SEVERE AND DISABLING MENTAL ILLNESS.

Objective 1: Contracts with community mental health centers will require that all adults with severe disabling mental illness who receive Department funded services have an identified case manager (July 1989).

Objective 2: The availability and quality of case management services will be enhanced by:

a) Completion of a program evaluation of the intensive case management program (October 1989).

b) Preparation of a report which documents the effectiveness of case management (January 1990).

c) Analysis of the number of case managers (intensive and supportive) needed to adequately serve adults with serious and disabling mental illness in Montana (January 1990).

d) Examination of potential funding sources and service priorities to find resources for additional case managers (Annually).

Objective 3: The use of jails to house mentally ill persons in crisis will be reduced by:

a) Determination of where in Montana jails are being used to house the mentally ill (October 1989).

b) Documentation of how other communities appropriately serve mentally ill persons in crisis. (October 1989)

c) Preparation of options for eliminating the use of jails to house the mentally ill. (January 1990)

Objective 4: Consumer-run drop-in centers will be developed in each region. (July 1991)

GOAL II: TO ESTABLISH A CLEAR DEFINITION OR "VISION" OF AN APPROPRIATE STATEWIDE COMMUNITY SUPPORT SYSTEM FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS.

Objective 1: A consultant will provide recommendations for a comprehensive service system for adults with severe disabling mental illness to Department staff and the Mental Health Advisory Council. (July 1989)

Objective 2: An empirical study of the service needs of a sample of adults with severe disabling mental illness will be conducted. (October 1989)

Objective 3: Based upon the results of Objectives 1 and 2, a description of an adequate service system for severely mentally ill adults, including the needed quantities of each service component, will be developed. (January 1990)

Objective 4: Through the mental health system planning process a proposal will be developed to structure the mental health system to include increased incentives for serving people locally and mechanisms for

local (CMHC) decision making on appropriate services for adults with severe disabling mental illnesses. (October 1990)

Objective 5: The mental health commitment law will be reviewed and proposals developed for any needed revisions. (October 1990)

GOAL III: TO MAINTAIN AND, WHERE NECESSARY, ENHANCE THE QUALITY OF CARE PROVIDED AT MONTANA STATE HOSPITAL AND THE MONTANA CENTER FOR THE AGED.

Objective 1: The adequacy of direct care and professional staffing levels at Montana State Hospital and the Montana Center for the Aged will be analyzed by:

a) Surveying other states regarding their staffing analyses methodologies for public inpatient psychiatric facilities. (August 1989)

b) Developing a method to assess direct care and professional staffing needs at Montana State Hospital and the Montana Center for the Aged. (October 1989)

c) Applying the methodology to the two facilities and comparing current staffing levels with staffing levels recommended by the analysis. (January 1990)

Objective 2: Recruitment and retention problems at Montana State Hospital will be analyzed by:

a) Surveying salary levels of staff at other states mental health facilities. (October 1989)

b) Studying sources of job satisfaction/dissatisfaction of Montana State Hospital staff. (October 1989)

c) Developing proposals to adjust salaries and/or other working conditions at Montana State Hospital. (January 1990)

Objective 3: A long range plan to bring the entire Montana State Hospital to full licensure will be developed. (June 1990)

GOAL IV: TO MAINTAIN AND STRENGTHEN A QUALITY ASSURANCE PROGRAM FOR THE COMMUNITY MENTAL HEALTH SYSTEM.

Objective 1: Review and, where necessary, revise standards for residential services purchased by the Department. This review will include, at a minimum, consideration of (October 1989)

a. treatment services;

b. patient rights and grievance procedures;

c. physical environment; and

d. handling of client funds.

Objective 2: Review and, where necessary, revise standards for adult day treatment programs. This review will include, at a minimum, consideration of: (October, 1989)

a. clearer definition of the scope of services provided within day treatment;

b. staffing ratios for all levels of program staff;

c. safety and sanitation standards; and

d. required paid work component.

Objective 3: Conduct on-site evaluations of all mental health programs funded by the Department. (Annually)

Objective 4: Revise quality assurance procedures to include some type of consumer involvement in program evaluation activities. (July 1989)

Objective 5: Develop and implement outcome measures as part of the Department's quality assurance activities. (July 1989)

Objective 6: Draft and provide to the Department of Health and Environmental Sciences, proposed amendments to community mental health center licensing standards which accurately describe the range of services and the organizational structure of community mental health centers. (October 1989)

Objective 7: Reach agreement with the Department of Health and Environmental Sciences regarding appropriate licensing requirements for mental health residential programs. (October 1989)

Objective 8: Establish and maintain an annual quality assurance cycle which includes: (October 1989)

a) Review and revision of program standards and evaluation procedures.

b) Input from evaluation results to contracting and planning processes.

c) On-site review of programs.

GOAL V: TO ASSIST IN MAKING MENTAL HEALTH SERVICES AVAILABLE TO PERSONS WHO ARE NOT DISABLED BY MENTAL ILLNESS.

Objective 1: Consultation and education funds will be targeted to meet identified prevention and early intervention needs. (July 1990)

Objective 2: Information on insurance will be developed and analyzed by

a) Surveying other states to determine insurance coverage for mental illnesses. (March 1990)

b) Developing a report on the extent and nature of insurance coverage for mental illnesses in other states and in Montana. (October 1990)

GOAL VI: TO PLAN AN INTEGRATED AND COMPREHENSIVE MENTAL HEALTH DATA SYSTEM.

Objective 1: Obtain technical assistance/consultation on data systems. (December 1989)

Objective 2: Develop a report on the data needs, cost, and implementation schedule of a comprehensive data system. (October 1990)

GOAL VII: IN COOPERATION WITH THE DEPARTMENT OF FAMILY SERVICES, ENHANCE MENTAL HEALTH SERVICES TO CHILDREN AND ADOLESCENTS.

Objective 1: Determine mental health service needs for children and adolescents, including residential, day treatment, case management, outpatient, and family therapy.

a. Compile and organize data stemming from Community Mental Health Needs Survey. (July 1989)

b. Distribute survey data to the ten Department of Family Services (DFS) planning councils. (August 1989)

c. Summarize the planning councils responses to the survey indicating how they would attempt to provide the services identified as not available. (September 1989)

Objective 2: Develop and sign written agreements with Department of Family Services to include clarification of each agency's responsibilities for services to children.

a. Research and develop a position paper outlining the Department's roles and responsibilities. (June, 1989)

b. Initiate contacts with the DFS to negotiate and develop a written agreement. (September, 1989)

Objective 3: Establish procedures and timelines for DFS input into the Department's planning, contracting, and evaluation process. (September 1989)

Objective 4: Develop improved local cooperation among mental health, education, social services, and juvenile justice agencies in planning and funding services for emotionally disturbed children and adolescents.

a. Provide to each of the local service areas established by DFS, a model local interagency agreement calling for a cooperative effort and procedures for: (October 1989)

1) Identifying youth requiring services because of mental disturbance;

2) Reviewing the service needs of the youth and his/her family on a case-by-case basis to cooperatively offer services to maintain children in their own home, or as close to home as possible; and

3) Cooperating in the development of programs to prevent out-of-home placements of children.

Objective 5: Develop cooperative arrangements among state and local-level agencies to fund services for emotionally disturbed children and adolescents.

a. In conjunction with local school districts, fund outpatient services for emotionally disturbed children and youth identified by schools. (October, 1989)

b. In cooperation with DFS, Department of Social and Rehabilitation Services (SRS), Office of Public Instruction (OPI), and local school districts, establish new community day treatment services for emotionally disturbed children. (October, 1990)

c. In cooperation with DFS, SRS, and OPI, develop and fund in-home therapeutic intervention services. (October, 1990)

d. In conjunction with DFS, SRS, and OPI, develop and fund residential services for emotionally disturbed adolescents who are sex offenders. (August 1991)

e. In cooperation with DFS, OPI, and SRS, develop prevention/early intervention services for children (ages 0-5) who are known to be at risk of developing emotional disturbances. (October 1992)

GOAL VIII: **IMPROVE THE QUALITY AND AVAILABILITY OF MENTAL HEALTH SERVICES TO GROUPS WHICH MAY BE UNDERSERVED, INCLUDING BUT NOT LIMITED TO: ELDERLY; NATIVE AMERICANS; AND DUALLY DIAGNOSED (MENTALLY ILL/MENTALLY RETARDED AND MENTALLY ILL/CHEMICALLY DEPENDENT) IN MONTANA.**

Objective 1: Report on the need for special categories of services/reimbursement for the elderly. Such categories may include, but are not limited to: (January 1990)

a) In-home treatment and evaluation.

b) Mental health support services in nursing homes.

c) Consultation and education services with senior citizens programs and other agencies or groups.

Objective 2: Develop local systems to identify elderly in need of mental health services and health care assistance. (June 1990)

Objective 3: Develop effective linkages/agreements with aging services, chemical dependency programs, and health care agencies to provide information, referral, and improved service coordination to elderly people who are mentally ill. (June 1990)

Objective 4: Establish a method to provide case management services for mentally ill elderly living at home. (July 1991)

Objective 5: Develop standards to improve chemical dependency services for dually diagnosed (MI/CD) clients including: required chemical dependency screening for eligible adult clients; required referral for evaluation if screening indicates chemical dependency problems; joint planning with chemical dependency service systems; and case management, which includes follow-up and referral. (October 1989)

Objective 6: Arrange staff training regarding culturally sensitive mental health services for minorities. (June 1990)

Objective 7: Require periodic outreach to urban Indian alliance offices by Department funded case managers. (July 1989)

Objective 8: Require by contract, outreach services to Homeless Mentally Ill. (July 1989)

GOAL IX: TO MAINTAIN AND STRENGTHEN THE MENTAL HEALTH PLANNING PROCESS WITH THE ASSISTANCE OF THE MENTAL HEALTH ADVISORY COUNCIL.

Objective 1: Annually review accomplishments, client fiscal and HRD data, and program evaluation results to establish tentative planning objectives. (September each year)

Objective 2: Systematically gather recommendations from providers, consumers, agencies, and interested citizens on planning issues and providers. (October each year)

Objective 3: Present issues and public input data to the Mental Health Advisory Council. (December each year)

Objective 4: Develop a draft plan (or revision). (January each year)

Objective 5: Hold public meetings for reaction to draft plan (or revision). (March each year)

Objective 6: Develop final mental health plan. (April each year)

Objective 7: Prepare quarterly reports on progress toward meeting Plan objectives. (Quarterly)

APPENDICES

APPENDIX A

PRIORITY GROUPS

The Department has defined the following priority groups. These priorities will be considered in the Department's planning and purchase of mental health services.

PRIORITY 1

Seriously Mentally Ill. The term "seriously mentally ill" is defined in state law [53-21-102(15), MCA] as a person of any age who is "...suffering from a mental disorder which has resulted in self-inflicted injury or injury to others or the imminent threat thereof, or which has deprived the person affected of the ability to protect his life or health".

PRIORITY 2

There are two distinct groups which comprise the Department's second priority for purchase of services:

1. Adults with Disabling Mental Disorders.

   These individuals include adults with severe and disabling mental illnesses, which is defined in Section II.1 of this Plan. This group also includes adults who have the following characteristics:

   a. The person has a diagnosed mental disorder; and

   b. The person requires services of extended duration as indicated by one or more of the following:

      i. the person has undergone inpatient psychiatric hospitalization at least twice, or

      ii. the person has received face-to-face unscheduled mental health crisis intervention services on at least three occasions, or

iii. the person has received at least 30 days of mental health day treatment or out-of-home residential services within the previous two years; and

c. The person has ongoing functioning difficulties because of the mental disorder as indicated by one of the following:

i. the person is unemployed or does not work in full-time competitive employment because of mental illness, or

ii. the person receives SSI or SSDI payments due to mental illness, or

iii. the person maintains or could maintain a living arrangement only with the ongoing supervision and assistance of family or a public agency.

2. Children and Adolescents in Need of Mental Health Services

Seriously mentally ill children and adolescents are included in the Department's first priority group described above. The provision of mental health services to children and adolescents who are not seriously mentally ill is, along with the provision of education, protective services, handicapped children's services, etc., also an important responsibility of state government. The Department's role in the children and adolescent mental health system is one of purchasing community treatment services. Services are purchased in consultation and coordination with the Department of Family Services, which is Montana's lead agency for children's services.

PRIORITY 3

The Department's third priority is to purchase services for adults who have mental health problems but who are not seriously mentally ill and do not have disabling mental disorders as defined above.

APPENDIX B

SUMMARY OF MAJOR COMMUNITY SUPPORT SYSTEM RESOURCES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS

Service Component	Capacity	Location(s)
Day Treatment	600-700 clients served monthly	Miles City, Billings, Havre, Great Falls, Livingston, Butte, Helena, Missoula, Kalispell, Sidney, Glendive
Transitional Living I (group homes)	92 beds	Miles City, Billings, Great Falls, Helena, Butte, Stevensville, Missoula, Kalispell
Support Employment (voc. rehab. funded)	40 service slots	Miles City, Billings, Great Falls, Helena, Butte, Kalispell, Missoula, Livingston
Intensive Case Management	18 FTE	Miles City, Glendive, Sidney, Billings, Livingston, Havre, Great Falls, Helena, Butte, Missoula, Kalispell
Short-Term Psychiatric Inpatient Services	150 beds	Miles City, Great Falls, Billings, Butte, Helena, Kalispell, Missoula
Outpatient Psychotherapy	CMHC Outpatient Clinics in 38 Communities	38 Communities

APPENDIX C.1

MONTANA GROUP HOME AND CHILD CARE AGENCY RESOURCES -
CONTRACTED FOR SERVICES BY DEPARTMENT OF FAMILY SERVICES

Service Component	Capacity	Location(s)
Foster Homes	1500 Homes	Statewide
Group Homes	12 Homes (103 beds)	Havre, Kalispell, Bozeman, Helena, Great Falls, Ronan, Shelby, Whitewater, Wolf Point, Missoula
Attention Homes/ Shelter Care	5 Homes (53 beds)	Anaconda, Missoula, Great Falls, Helena, Billings
Care & Professional Treatment Homes	One program, capacity open, Average pop. - 20	Billings area
Receiving Homes	3 Homes (29 beds)	Ronan, Great Falls, Missoula
Sexual Abuse Treatment Programs	2 Programs (capacity - 17)	Glasgow Billings
Maternity Homes	One Program, Capacity - 15	Helena
Residential Child Care Agencies	2 Programs (capacity - 122)	Billings Helena

Additionally, there are 128 licensed short-term psychiatric beds available for children in the state. The three private in-patient facilities are located in Billings, Butte and Helena.

APPENDIX C.2

DEPARTMENT OF FAMILY SERVICES -
CLIENT DATA BASE SYSTEM - FY 1988

Component	# Receiving Service	
Regular In-State Foster Home Care	1,912	
Regular Out of State Foster Home Care	45	
Foster/Adoptive Home Care	29	
Foster Group Home Care	264	
Foster Developmental Disabilities Group Home Care	5	
Attention Home care (Shelter Care)	818	
In-State Treatment (Residential or Therapeutic Foster Care)	224	
Out of State Treatment (Residential)	65	
Special Needs/Support Services for Developmentally Disabled in Foster Care	36	
Special Needs/Support Services for Others in Foster Care	313	
Unduplicated Total		2,792*
Drug/Alcohol Treatment (Indigent Youth)	44	
Subsidized Adoptions	91	
Unduplicated Total		2,927*

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* The percentage of this number of children and youth that are emotionally disturbed is unknown.

APPENDIX D

MONTANA MENTAL HEALTH ADVISORY COUNCIL

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Glasgow, MT 59230

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Peggy Williams
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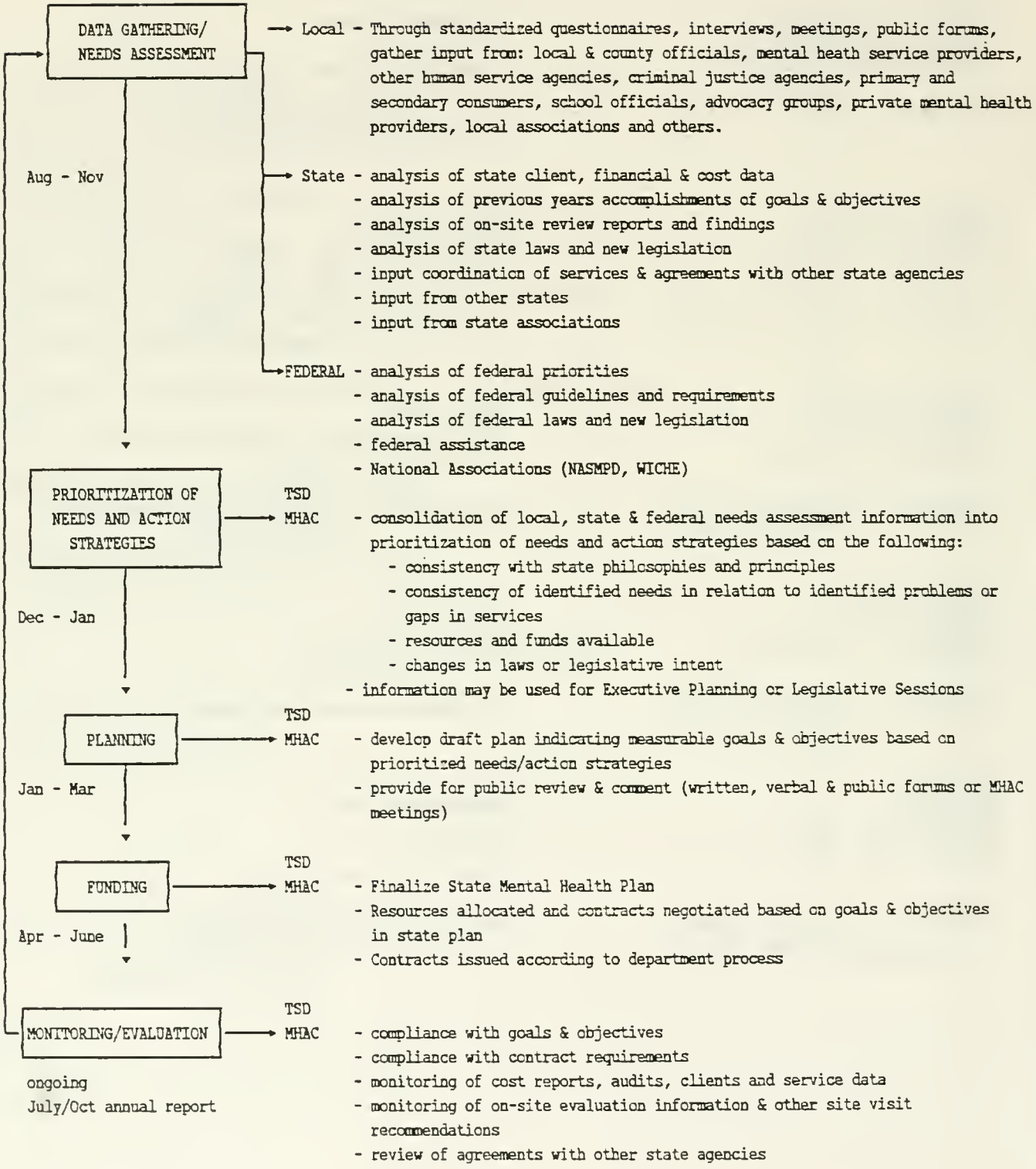
444-2590 (Work)

APPENDIX E

MENTAL HEALTH
PLANNING PROCESS

TSD=Treatment Services Division
Department of Institutions

MHAC=State Mental Health
Advisory Council


DATA GATHERING/
NEEDS ASSESSMENT
Local - Through standardized questionnaires, interviews, meetings, public forums, gather input from: local & county officials, mental heath service providers, other human service agencies, criminal justice agencies, primary and secondary consumers, school officials, advocacy groups, private mental health providers, local associations and others.
Aug - Nov
State - analysis of state client, financial & cost data
- analysis of previous years accomplishments of goals & objectives
- analysis of on-site review reports and findings
- analysis of state laws and new legislation
- input coordination of services & agreements with other state agencies
- input from other states
- input from state associations
FEDERAL - analysis of federal priorities
- analysis of federal guidelines and requirements
- analysis of federal laws and new legislation
- federal assistance
- National Associations (NASMPD, WICHE)
PRIORITIZATION OF NEEDS AND ACTION STRATEGIES
TSD
MHAC
- consolidation of local, state & federal needs assessment information into prioritization of needs and action strategies based on the following:
- consistency with state philosophies and principles
- consistency of identified needs in relation to identified problems or gaps in services
- resources and funds available
- changes in laws or legislative intent
- information may be used for Executive Planning or Legislative Sessions
Dec - Jan
PLANNING
TSD
MHAC
- develop draft plan indicating measurable goals & objectives based on prioritized needs/action strategies
- provide for public review & comment (written, verbal & public forums or MHAC meetings)
Jan - Mar
FUNDING
TSD
MHAC
- Finalize State Mental Health Plan
- Resources allocated and contracts negotiated based on goals & objectives in state plan
- Contracts issued according to department process
Apr - June
MONITORING/EVALUATION
TSD
MHAC
- compliance with goals & objectives
- compliance with contract requirements
- monitoring of cost reports, audits, clients and service data
- monitoring of on-site evaluation information & other site visit recommendations
- review of agreements with other state agencies
ongoing
July/Oct annual report

APPENDIX F

HUMAN RESOURCE DEVELOPMENT PLANNING ISSUES

To assure broad based input on human resource development issues, the director of the Montana Human Resource Development (HRD) Project works with an HRD Committee comprised of representatives from the five mental health regions, Montana State Hospital, and consumer/advocate representatives. The Committee generated a list of HRD issues using input from the community mental health centers, the state hospital, consumers, advocates, and other human service providers. These issues were then rated by these same constituencies as to their perceived importance to the public mental health system. The HRD Committee used this input to recommend issues the Mental Health Bureau should address in the state Mental Health Human Resource Development (MHHRD) Plan.

Thirteen human resource issues have been identified for inclusion in the MHHRD Plan. These issues are listed below in priority order.

High Priority

Knowledge of effective community based models to serve severely emotionally disturbed children and adolescents needs to be more effectively disseminated to the public mental health workforce.

There are difficulties retaining mental health professionals throughout the public mental health system.

Medium-High Priority

There are difficulties in recruiting qualified professionals for employment within the public mental health system.

Existing linkages between mental health service delivery systems and higher educations systems need to be strengthened in order to improve services to public sector populations.

New information about and approaches to working with persons who have a severe and persistent mental disorder and their families needs to be more adequately disseminated to the public mental health workforce. This includes knowledge as to the needs of families and means to work effectively with them.

There is a lack of communication and service coordination between mental health professionals and advocates for the severely mentally ill.

A management information system which incorporates workforce variables, integrates the various data sets, is compatible across the entire public mental

health system, and is usable for administrative planning an decision making needs to be developed.

There are difficulties in recruiting and retaining professionals to staff rural mental health offices.

A procedure needs to be developed which will provide consultation for rural staff to help them deal effectively with clients which require knowledge and/or skills which they do not possess.

Salaries for professional staff within the public mental health system are not competitive.

MEDIUM PRIORITY

Linkages between the public mental health system and other service systems at the state, regional, and local levels need to be strengthened in order to improve services to public sector populations.

There is a need to develop a system which places emphasis on providing quality workshops and in-service training within the state, other resources to maintain competency (e.g., computer access to journal articles), and incentives for increased skill development and self-directed study.

Educational programs which prepare students to become mental health professionals need to become more responsive to the needs of the mental health system.

APPENDIX G

MONTANA STATE HOSPITAL

FY 1988 Expenditures and Average Daily Population *

WARM SPRINGS

Unit	ADP	Expenditures
Long Term Unit	42.5	$ 1,783,190
Forensic Unit **	70.9	3,557,386
Intake Unit	11.5	989,939
Intensive Treatment Unit	48.2	2,361,596
Extended Treatment Unit	83.4	3,513,884
Pre-release	32.0	1,180,770
	288.5	$13,386,765

Funding	
General Fund	$13,292,566
Federal	5,607
Other	88,592
	$13,386,765

GALEN

Unit	ADP	Expenditures
Acute Care	14.9	$1,985,386
Nursing Home	85.0	3,349,969
Alcohol Service Center	66.2	1,778,128
Lighthouse	12.3	528,577
	178.4	$7,642,060

Funding	
General Fund	$5,991,676
Alcohol Earmarked	1,595,600
Other	54,784
	$7,642,060

* Unit expenditures are based on direct costs per unit plus indirect costs allocated by ADP per unit.

** The Forensic Unit serves persons ordered to the hospital through criminal code procedures, Montana State Prison inmates who become seriously mentally ill, and other Montana State Hospital patients whose dangerous behavior requires a high security environment.

APPENDIX H

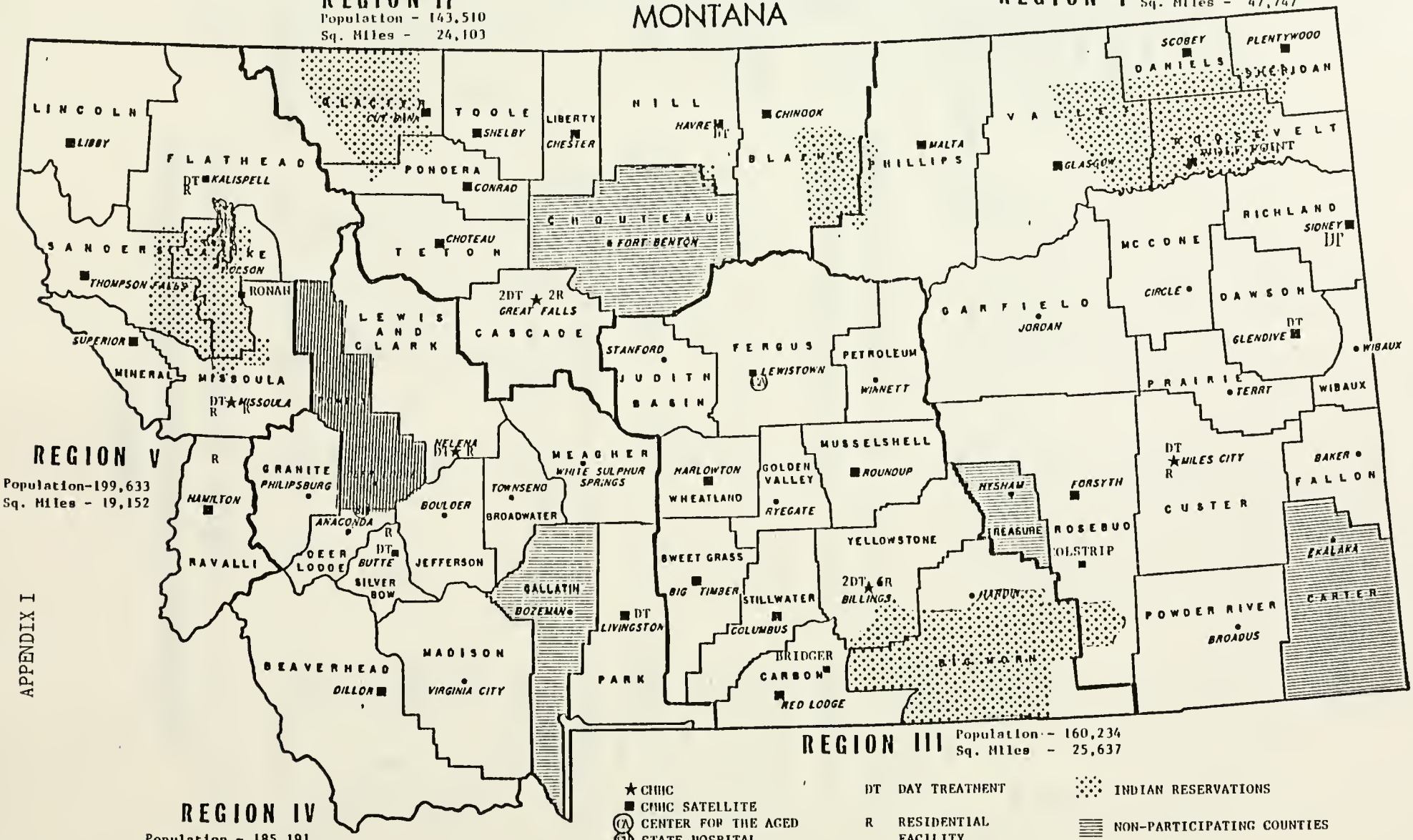
MONTANA STATE HOSPITAL (Warm Springs Campus) CASELOAD
By Sex and Diagnosis

(June 30, 1988 Caseload)

	Male	Female	Total
Mental Retardation	4	1	5
Conduct Disorders	2	1	3
Specific Development	1		1
Primary Degenerative Dementia	5	2	7
Substance (Drug) Related Disorders	4	1	5
Alcohol Abuse	8		8
Alcohol Related Organic Mental Disorders	4		4
Other Organic Mental Disorders	16	6	22
Schizophrenic	111	40	151
Schizophreniform	1		1
Schizoaffective	10	13	23
Paranoid	1		1
Bipolar	6	3	9
Major Depressive	1	4	5
Dysthymia		3	3
Anxiety (Adult)	2		2
Sexual	4		4
Personality & Other Impulse	13	10	23
Adjustment	3		3
Social Conditions	1	1	2
Diagnosis Deferred		1	1
Total	197	86	283

MENTAL HEALTH SYSTEM (as of 10/01/87)

MONTANA



APPENDIX I

APPENDIX J

COMMUNITY MENTAL HEALTH CENTER ADMISSIONS BY AGE

(Unduplicated Admissions and Readmissions; 7/1/87 - 6/30/88)

Age Range	Reg 1	Reg 2	Reg 3	Reg 4	Reg 5	Total	
0 - 11	218	89	113	148	153	721	(8.4%)
12 - 17	261	154	275	247	193	1,130	(13.2%)
18 - 64	880	1,119	1,799	1,027	1,367	6,192	(72.3%)
65+	120	49	130	42	29	370	(4.3%)
Unknown	4	53	8	49	43	157	(1.8%)

Community Mental Health Center Admissions by Sex

(Unduplicated Admissions and Readmissions; 7/1/87 - 6/30/88)

Sex	Reg 1	Reg 2	Reg 3	Reg 4	Reg 5	Total	
Male	670	674	1,028	619	734	3,725	(43.5%)
Female	813	774	1,297	876	1,020	4,780	(55.8%)
Unknown	0	16	0	18	31	65	(0.7%)

Community Mental Health Center Admissions by Ethnic Group

(Unduplicated Admissions and Readmissions; 7/1/87 - 6/30/88)

Ethnic Group	Reg 1	Reg 2	Reg 3	Reg 4	Reg 5	Total	
White	1,247	1,297	2,113	1,406	1,617	7,680	(89.6%)
Native Am.	132	91	140	42	114	519	(6.1%)
Black	18	25	0	7	2	52	(0.6%)
Hispanic	9	10	40	14	11	84	(1.0%)
Asian	0	2	0	4	4	10	(0.1%)
Other	6	3	32	4	7	52	(0.6%)
Unknown	71	36	0	36	30	173	(2.0%)

APPENDIX K

COMMUNITY MENTAL HEALTH CENTER CASELOADS BY DIAGNOSIS

(June 30, 1988 Caseloads)

DSM-III Category	Reg 1	Reg 2	Reg 3	Reg 4	Reg 5	Total
Disorders First Evident in Childhood	140	92	115	120	39	506
Organic Disorders	75	35	78	24	14	226
Substance Use Disorders	35	62	193	34	22	346
Schizophrenic Disorders	83	221	195	193	155	847
Other Psychotic Disorders	12	41	41	38	35	167
Affective Disorders	123	238	511	167	228	1,267
Anxiety Disorders	218	153	133	258	33	795
Somatoform Disorders	5	6	3	3	6	23
Disassociative Disorders	3	3	1	1	3	11
Psychosexual Disorders	19	2	2	25	3	51
Factitious Disorders	0	0	0	0	1	1
Other Impulse Contact Disorders	15	5	16	8	7	51
Adjustment Disorders	237	376	416	307	159	1,495
Psychological Affecting Physical	4	6	4	2	3	19
Personality Disorders	125	96	157	160	20	558
Paranoid	2	5	0	7	5	19
Conditions Not Attributable to a Mental Disorder	21	101	83	79	181	465
Additional Codes	15	35	41	65	77	233
Unknown	0	137	4	0	27	168
Total Caseload	1,132	1,614	1,993	1,491	1,018	7,248

APPENDIX L

WARM SPRINGS ADMISSIONS BY COUNTY AND REGION

July 1, 1986 through June 30, 1988

COUNTY	INVOLUNTARY	PER 100,000 POPULATION	VOLUNTARY	PER 100,000 POPULATION	OTHER	PER 100,000 POPULATION	TOTAL	PER 100,000 POPULATION
REGION I								
Carter			1	55.56			1	55.56
Custer	6	44.78	6	44.78	5	37.31	17	126.87
Daniels								
Dawson	4	33.90	4	33.90	4	33.90	12	101.69
Fallon	1	26.32					1	26.32
Garfield			1	58.82			1	58.82
McCone					2	76.92	2	76.92
Phillips					2	35.09	2	35.09
Powder River	1	41.67	3	125.00			4	166.67
Prairie	1	55.56					1	55.56
Richland	5	35.97	3	21.58	2	14.39	10	71.94
Roosevelt	4	34.19	10	85.47	2	17.09	16	136.75
Rosebud	2	15.87	4	31.75	5	39.68	11	87.30
Sheridan	1	17.24	2	34.48	2	34.48	5	86.21
Treasure								
Valley	2	20.62					2	20.62
Wibaux	1	71.43					1	71.43
TOTAL	28	26.97	34	32.76	24	23.12	86	82.85
REGION II								
Blaine			2	28.17			2	28.17
Cascade	18	22.28	38	47.03	38	47.03	94	116.34
Choteau	1	16.39	1	16.39	1	16.39	3	49.19
Glacier			8	70.80	3	26.55	11	97.35
Hill	5	27.47	5	27.47	2	10.99	12	65.93
Liberty	1	40.00			2	80.00	3	120.00
Pondera	1	14.49	6	86.96	3	43.48	10	144.93
Teton					1	15.38	1	15.38
Toole			1	17.54			1	17.54
TOTAL	26	17.92	61	42.04	50	34.46	137	94.42
REGION III								
Big Horn	1	8.62			2	17.24	3	25.86
Carbon	2	23.26	1	11.63	1	11.63	4	46.51
Fergus	7	54.26	6	46.51	5	38.76	18	139.53
Golden Valley					1	90.91	1	90.91
Judith Basin					1	37.04	1	37.04
Musselshell	1	20.83			2	41.67	3	62.50
Petroleum								
Stillwater			1	16.39			1	16.39
Sweet Grass			2	60.61	1	30.30	3	90.91
Wheatland					2	90.91	2	90.91
Yellowstone	113	93.78	96	79.67	36	29.88	245	203.32
TOTAL	124	71.06	106	60.74	51	29.23	281	161.03
REGION 4								
Beaverhead	2	23.53	7	82.35	2	23.53	11	129.41
Broadwater	3	85.71	6	171.43	5	142.86	14	400.00
Deer Lodge	14	127.27	30	272.73	16	145.45	60	545.45
Gallatin	7	14.64	25	52.30	15	31.38	47	98.33
Granite			1	37.04	3	111.11	4	148.15
Jefferson	2	25.00	6	75.00	2	25.00	10	125.00
Lewis & Clark	46	99.78	73	158.35	24	52.06	143	310.20
Madison	3	51.72	4	68.97	2	34.48	9	155.17
Meagher			1	45.45	1	45.45	2	90.91
Park	2	15.04	5	37.59	8	60.15	15	112.78
Powell	5	72.46	19	275.36	9	130.43	33	478.26
Silver Bow	23	66.47	120	346.82	52	150.29	195	563.58
TOTAL	107	56.20	297	155.99	139	73.00	543	285.19
REGION 5								
Flathead	25	43.63	45	78.53	5	8.73	75	130.89
Lake	3	14.49	5	24.15	8	38.65	16	77.29
Lincoln	16	85.11	4	21.28	5	26.60	25	132.98
Mineral								
Missoula	37	47.87	57	73.74	28	36.22	122	157.83
Ravalli	4	16.19	6	24.29	5	20.24	15	60.73
Sanders	1	10.99	4	43.96	3	32.97	8	87.91
TOTAL	86	40.64	121	57.18	54	25.52	261	123.35
STATE TOTAL								
TOTAL ADMISSIONS	371	44.95	619	74.99	318	38.53	1,308	158.47

APPENDIX M

COMMUNITY MENTAL HEALTH SERVICE NEEDS SURVEY

The top ranked initiatives for each client population group based on responses to the survey are as follows:

I. CHILDREN/ADOLESCENTS IN NEED OF MENTAL HEALTH SERVICES

1. Develop improved local cooperation among mental health, education, social services, and juvenile justice agencies in planning and funding services for emotionally disturbed children and adolescents.

2. Develop prevention/early intervention (ages 0-5) services for children who are known to be at risk of developing emotional disturbances.

3. Develop and fund "family teaching" services to assist parents in dealing with behavioral disorders in children and adolescents.

4. Develop and fund in-home therapeutic intervention services.

5. Develop cooperative arrangements among state-level mental health, family services and education agencies to fund services for emotionally disturbed children and adolescents.

II. ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS

1. Fund additional group homes.

2. Fund additional intensive case manager positions.

3. Develop community services which are directly related to reducing the patient population at Montana State Hospital.

4. Fund semi-independent living services.

5. Expand availability of supported employment services.

III. ADULTS, AGES 18-64, WHO HAVE MENTAL HEALTH PROBLEMS

1. Work for better insurance coverage of treatment for mental illness.

2. Fund early intervention services to prevent development of disabling illness.

3. Provide outpatient therapy services in communities where it is not currently available.

4. Fund consultation and education services to improve public awareness/ knowledge of mental illness and available treatment.

5. Fund specialized therapy programs for adults who were sexually abused as children.

IV. ADULTS, AGES 65 AND OLDER, WITH MENTAL HEALTH PROBLEMS

1. Develop effective linkages/agreements with aging services, chemical dependency programs and health care agencies to provide information, referral and improved service coordination.

2. Fund case management positions for mentally ill elderly living at home.

3. Provide in-home therapy services for the elderly.

4. Require the development of local systems to identify elderly in need of mental health services and health care assistance.

5. Develop multiagency in-home service teams.

V. MINORITIES WITH MENTAL HEALTH PROBLEMS

1. Require staff training regarding culturally sensitive mental health services for minorities.

2. Fund special outreach activities to identify minorities with severe mental disabilities.

3. Require recruitment and training of additional minority staff in state funded mental health programs.

4. Require identified minority services coordinator/specialist in each state funded mental health program.

VI. HOMELESS PEOPLE WHO ARE MENTALLY ILL

1. Develop active outreach to shelters and other programs serving the homeless to identify mentally ill people.

2. Provide early intervention services for children living with homeless families.

3. Develop coalitions with other service providers to improve service coordination for the homeless mentally ill.

4. Develop additional intensive case manager positions to specialize in serving the homeless mentally ill.

5. Provide mental health services in shelters serving the homeless.

APPENDIX N

MENTAL HEALTH ADVISORY COUNCIL PRIORITIES

The Montana Mental Health Advisory Council met in December, 1989 to consider 48 issues which had been raised during the planning process. The Council grouped these issues according to priority into four categories. Within the categories, individual ratings were not established.

I. VERY HIGH PRIORITY

1. Develop methods to reduce the use of jails to house people who are mentally ill.

2. Work for better insurance coverage of treatment for mental illness.

3. Fund additional intensive case manager positions.

4. Develop community services which are directly related to reducing the patient population at Montana State Hospital.

5. Develop a funding system that would provide incentives to serve severely mentally disabled people locally rather than hospitalizing them at Montana State Hospital (intended to include consideration of allocating funds to local or regional entities).

6. Consider developing specific crisis intervention services for seriously mentally disabled adults.

7. Develop requirements regarding follow-up for people being discharged from Montana State Hospital.

8. Consider regional centers to provide inpatient psychiatric services currently provided by Montana State Hospital.

9. Review and, where necessary, propose revisions to mental health commitment law.

10. Fund additional group homes (for adults).

11. Address recruitment issues at Montana State Hospital (especially as related to salary and classification system).

12. Develop staffing analysis methodology based on level of care and training needs (Montana State Hospital and Center for the AGed).

II. HIGH PRIORITY

13. Develop improved local cooperation among mental health, education, social services, and juvenile justice agencies in planning and funding services for emotionally disturbed children and adolescents.

14. Develop cooperative arrangements among state-level mental health, family services and education agencies to fund services for emotionally disturbed children and adolescents.

15. Fund child/adolescent day treatment in communities where the service is currently unavailable.

16. Develop and fund specialized community based services for emotionally disturbed adolescents who are sexual offenders.

17. Develop active outreach to shelters and other programs serving the homeless to identify mentally ill people.

18. Periodic outreach to urban Indian Alliance offices by case managers.

19. Arrange for CMHCs to provide training to agencies serving the homeless (regarding screening/assessments, referral and mental health services).

20. Develop prevention/early intervention (ages 0-5) services for children who are known to be at risk of developing emotional disturbances.

21. Develop and fund "family teaching" services to assist parents in dealing with behavioral disorders in children and adolescents.

22. Develop and fund in-home therapeutic intervention services (for children and adolescents).

23. Develop capability to provide respite care to families of severely mentally disabled adults.

III. PRIORITY

24. Fund additional therapeutic foster care.

25. Expand availability of supported employment services.

26. Provide chemical dependency services at Warm Springs campus of Montana State Hospital.

27. Pursue licensing for Montana State Hospital

IV. OTHER IMPORTANT ISSUES

28 Fund early intervention services to prevent development of disabling illness.

29. Fund semi-independent living services.

30. Require the development of local systems to identify elderly in need of mental health services and health care assistance.

31. Provide in-home therapy services for the elderly.

32. Require increased vocational emphasis in day treatment programs.

33. Develop multi-agency in-home service teams (for the elderly).

34. Develop effective linkages/agreements with aging services, chemical dependency programs and health care agencies to provide information, referral and improved service coordination (for the elderly).

35. Develop itinerant case management services for rural communities.

36. Require chemical dependency services in state funded day treatment programs.

37. Develop and fund additional therapeutic group homes for emotionally disturbed children and adolescents.

38. Develop aftercare residential settings for youth being discharged from inpatient psychiatric programs.

39. Develop a state operated inpatient psychiatric program for children and adolescents.

40. Fund consultation and education services to improve public awareness/ knowledge of mental illness and available treatment.

41. Provide outpatient therapy services in communities where it is not currently available.

42. Make available training for CMHC staff on issues of cultural sensitivity to minorities.

43. Support the creation of consumer run drop-in center(s).

44. Clarify CMHC's and Department's responsibility regarding "no discrimination on the basis of ability to pay."

45. Pursue accreditation for Montana State Hospital.

46. Strengthen the involvement of consumers in areas of policy, planning, and evaluation.

47. Consider the development of effective methods of disseminating information to parents and staff regarding mental health services and issues.

48. Study crisis intervention services in terms of need, availability, method(s) of delivery, and funding mechanisms.